PTP USER MANUAL

Physiotherapist's Progress/Discharge Report **WCB Claim No.: ________________________________**

Clinic No.: ______________PT No.: _______________Personal Health No.: ______________________________

Phone No.: ____________Fax No.: _______________Date of Birth ______________ Phone No.: ____________

Employer Name ________________________________

Physician's Name, Address, Postal Code

Worker Name, Address, Postal Code

Print/stamp/sticker

Print/stamp/sticker

Clinic Name __________________________________

(Please note: All sections need to be filled out where appropriate to insure reimbursement for the PTP form.)

REQUEST FOR EXTENSION ☐ **DENIED CES/CM ______________________Date ___________***(Note that case management will be considering assessment of recovery and duration, frequency of treatments as well as other features of recovery in approving further treatment at a primary level or if a decision will be made to proceed with a multi-disciplinary assessment.)*

1. **Current Diagnosis____________________***(Be as specific as possible)*
2. **Body areas being treated__________________________________***(Be as specific as possible)*
3. **Subjective Complaints** *(Use quantifiable measures where possible i.e. Numeric pain scale rating)*
4. **Objective Findings** *(Use quantifiable measures where possible i.e. Range of motion, straight leg raise testing, manual muscle testing, deep tendon reflex testing.)*
5. **Assessment of recovery (0-10)________**0 = No recovery, 10 = recovered to preinjury

Explain any delay in recovery ____

(The assessment of recovery is a measure that asks the provider to summarize available information to provide an estimate of the expectation of recovery within typical primary timelines. The clinician is asked to incorporate clinical findings, self-report measure change, objective functional change where testing is appropriate as well as possible psychosocial issues. A score between 0 and 10 representing no recovery and 10 representing recovery to pre-injury status is established. This score will represent the practitioners' assessment of the complexity of this primary patient's presentation and potential for recovery.)

6. Discharged ☐ ***Yes date:*** *(Include the final date of treatment.)* ☐**No** *requires a Request for Extension of Treatment(complete #7 - 18)*

7. Restrictions ☐ **Subjective** ☐ **Measured**

☐**lifting (# of lbs.) _____** ☐**pushing/pulling (# of lbs) _____**

☐**Reaching** ☐**overhead reaching** ☐**turning** ☐**walking _____** ☐**stairs** ☐**ladders** ☐**standing (# of hrs) ___**

☐**sitting (# of hrs) ____** ☐**environment ________________________** ☐**Other ____________________________**

(Use the boxes above to indicate if the restrictions that are provided are based on functional testing (where appropriate) or by client perception of function in combination with clinical judgment. If it is your clinical opinion that the worker is not suitable for work of any kind at this time, then the restriction sections should be left blank. Your rationale for indicating the worker's inappropriateness for return to work of any kind should be included in the comments section)

8. Have you advised the patient to be off work due to injury ☐**Yes** ☐**No (If Yes, complete #9 - 18)**

If NO, is the patient to be working with restrictions ☐**Yes** ☐**No (If Yes, complete #9 - 18)**

9. Self Report (initial/current) Roland Morris __/__Quick Dash __/__ QD Work module __/__ NDI __/__ LEFS __/__

(The self-report measures have been developed based on instruments that were established at the Outcome Measures Workshop in May 2006. The instruments chosen are based on body parts involved i.e. Roland Morris for thoracic and lumbar spine, Quick Dash for upper quadrant, and NDI for cervical spine and LEFS for lower quadrant injuries. It is mandatory to use the instruments described above. Please include the raw score for the initial and the current measure when providing the information about the self-report measure.)

10. Treatment Plan ☐Chiropractic ☐Massage ☐Biomechanical ☐Electrophysical

☐Regional conditioning, Supervised __ Home __ ☐Supervised global conditioning ☐RTW

☐Other ____

11. Frequency of treatment: _____per week **12. Expected number of week to discharge.________________**

13. Are you aware of other health or non-health factors affecting recovery ☐No ☐Yes *(If Yes, add to Comments)*

14. The effects of the injury may affect activity for: # of days < 8_____ ☐8–14 ☐15-21 ☐>21 RTW Date _________

(The expectation is for an estimation based on the available information at the time of the progress report)

15. Has a return to work plan been discussed with the worker? ☐Yes ☐No the employer? ☐Yes ☐No

16. Has a return to work plan been arranged: ☐Yes TRTW start date ______ ☐No *(Explain barriers in Comments)*

17. Are there any specific safety concerns in a RTW ☐No ☐Yes *(If yes, explain in comments)*

18. Comments *(This section is included to expand on issues related to the return to work, i.e. work place issues, psychosocial issues or non-compensable issues delaying recovery, concerns regarding safety related to medications).*

Signature:___________________________Date____________Copy to _________________________________